**Employment and Substance Use Disorders\_ The Individual Placement and Support (IPS) Model**

**Introduction:**

ANN: Good afternoon, everyone. Thank you for logging on to our webinar, Employment and Substance Use Disorders-- The Individual Placement and Support Model. Just a couple of housekeeping details right away. The webinar will be recorded and available, along with the PowerPoint slides, on our website.

Today's audio is broadcast through your computer speakers so please make sure that your speakers are turned on and up. There's no call in number available. So if you have questions, please feel free to put them in the chat box, and we will address them at the Q&A session to be held after the presentation.

Our speakers today are Lou Kurtz. Lou is currently the co-director of the Great Lakes Mental Health Technology Transfer Center. He's previously worked for the Kentucky Department of Behavioral Health Development and Intellectual Disabilities in a variety of roles, as well as at Eastern Kentucky University. From 2010 to 2015, Lou served as the mental health lead for the Kentucky IPS Supported employment program. And more recently, has conducted fidelity monitoring for local IPS programs in Kentucky. And provided consultation services for national supported employment demonstration projects.

Louis worked in community health and state agencies for the past 37 years, with experience in affordable housing development, supported housing, homeless services, crisis stabilization, and evidence-based practices for adults with serious mental illnesses. He holds a bachelors of science degree in psychology, from Pennsylvania State University and a master's in education in vocational rehab counseling, from the University of Texas, in Austin.

Our other speaker today is Bob Meyer, who is currently the technology transfer specialist with the STR-TA region covering Minnesota, Wisconsin, and Illinois. Bob was the state trainer for the Wisconsin Individual Placement and Support Project-- a team effort with the Department of Health Services division of vocational rehab and the UW Madison Department of Rehab, Psych, and Special Ed.

Bob worked at the IPS program in Wisconsin from 2010 to 2018, for the first three pilot sites. Through expansion to community mental health programs-- that number has grown to over 65 sites in 26 counties. The average employment rate for individuals in the program has also increased from 18% to 47% over that time.

Bob has worked at the University of Wisconsin in Madison as a researcher and outreach specialist. And has published results of projects working in the fields of disability, human factors, and employment for the last 20 years.

In 2017, NAMI recognized Bob with the government service IFS award. Bob received his bachelor's degree in education from the University of New Mexico and his master's degree and subsequent research training from the University of Wisconsin, Madison, in the industrial and systems engineering department. So we're happy to have you both.

**Presentation**:

BOB MEYER: Good morning, everyone. Can everyone here me? Or Anne, can you give us a mic check-- we're working OK?

ANN: We can hear you.

BOB MEYER: So Lou and I will be doing the-- this is Bob Meyer, by the way-- we'll be doing a presentation today. If you've got any questions, feel free to type those into the Q&A box. And then we'll go over those at the end. Or if there's something that comes up in the middle that's pertinent to the slide we're on, we'll go ahead and jump right in, and answer those questions as they come up.

So one of the things we wanted to talk about was-- in general-- using employment not as an indicator of recovery, but as a treatment plan or a part of recovery. A lot of times, employment is seen as an end result, or as a step along the way, or when you're all done with recovery, then you can get a job.

And what we found with IPS and through working with this over the years is that employment's an integral part of that recovery process. And it goes differently for everyone. But if we keep that in mind, no matter where a person's at and we meet them where they're at, and work with them-- then employment really works as a way to help rebuild capital in their lives. Recovery capital in terms of having some sense of being able to manage their affairs, have a social contact with things.

If we think about employment for most of us, it's kind of our identity. You usually introduce yourself with your name and what you do. And for somebody that has either a mental health disorder or a substance use disorder-- a lot of times, they're not going to go out and introduce themselves in saying hi my name's Bob, and I'm unemployed and on disability.

They want to be able to say something-- they want to say I work at the clothing store. I work at a grocery store. I'm a researcher-- whatever it is that they happen to be doing. And we found that folks are very capable of working. And that work is an important part of their recovery process.

So the Individual Placement and Support supported employment model-- and we're going to abbreviate this as IPS-- the IPS model is probably, the most researched evidence-based employment model out there. At this point, actually, I think our slides are a little bit off. I just learned that last week, that they're actually now 26 randomized controlled trials that have been studying the IPS model all over the place. And we'll take a look at where those have happened, and what the results are.

It was originally developed in New Hampshire, with a small mental health team where they integrated employment into it. And they we're finding that they had just really incredible results compared to standard treatment. Which might have been when somebody said they wanted to work, they'd send them to their division of vocational rehabilitation or to an employment agency. And they wouldn't really know what was happening with the mental health treatment team because they were separate.

So what they did differently is they integrated it into their treatment team. And as part of that-- they realized, wow, this really works well. And they came up with some overriding principles that we're going to go over, that helped to define what is an IPS program.

So again-- like I said-- the main thing is they're integrated into an employment. Even though they started out testing it in New Hampshire and they looked at it and they went to the federal agencies, and said hey, look, this is a really great program-- they said yeah, but New Hampshire's kind of small and rural. And it's awfully homogeneous when it comes to other factors, as far as race, and ethnicity, and that.

They said, why don't you try it somewhere else and let us know what happens. So they went into inner city DC and worked in-- I think-- it was a homeless shelter, that also had a high number of folks with substance use disorder. And they got the exact same results there as they did in New Hampshire. And they-- well, maybe we're onto something here. And then they started to test it in other places.

Some folks are having trouble of not being able to hear me OK. If I move closer, is this working better for folks that are trying to hear? I'll also slow down a little bit, too. I get a little excited and go quickly.

So we're going to integrate employment into treatment recovery process. And what we'll try to do-- while we're talking about this-- is look at how this might look with a traditional sort of substance abuse disorder treatment team, as well as a regular mental health treatment team, as well.

So one of the first things we'll go through is the eight principles that guide IPS services. And these were developed over the years-- these come from the IPSWorks.org website-- which is the national IPS learning collaborative and actually, an international IPS learning collaborative. They're in 24 states right now around the country. And, I think, four or five different countries, as well-- New Zealand, Montreal, Spain, Italy, the Netherlands. We also work with folks from Iceland and other places, where they've implemented IPS.

So one of the main things that's one of the overriding principles is that the jobs that we help folks find are all competitive jobs. So there are no set aside jobs. No sheltered workshops. We don't have enclave-type jobs, where they're set aside for people from a special group or a treatment facility. It's a job that anybody else can apply for. And the goal is that they make the same wage as anybody else does who's doing the same job.

So around here in Madison, Wisconsin, the unemployment rate is fairly low. So most of the jobs that people start at around here are above the federal minimum wage. So we will want everybody else starting at the same rate as everybody else for that type of job. And that-- for some folks-- that's a bit of a change.

Traditionally in mental health services, they were offered shelter work options where they might go in and get paid piece rate to do something-- some task. Or a lot of times, they were just led toward volunteer positions and other things like that, where it really didn't do much for their income-- for one. But it also, let them separate them and away from everybody else.

The systematic part of it is when it comes down to looking at the job fit that our employment specialists who are part of the team-- so a team would be an employment specialist, and supervisors, and a vocational rehabilitation counselor. And those are the folks that we integrate into the rest of the mental health treatment team or substance use disorder team.

So that systematic job development is where employment specialists go out into the community, and they will work with employers to learn about what are the characteristics of the jobs, the characteristics of the place of employment. Because a lot of times, what might be happening is that something within there is not a good job fit for the person, although they might be able to do the tasks.

So one example of this might be if you had a construction worker or something who was having a substance use disorder, maybe, around drinking or something like that. And all the places this person kept looking for work, he'd find that they'd have fairly heavy drinking culture after work. So our employment specialist would work to either find a construction firm where that's not as applicable or is not as prevalent. Or they might work with them on being, like, an independent contractor or something. Where they're able to do things on their own and then, separate themselves from what might be a trigger for them.

One of the goals in this is that all of our employment specialists go out and meet with at least six different employers every single week. And that maintains no matter how many people are on their caseload or even how many people are working. If we get a lot of people working, then they can reduce that because they're doing a lot more follow-up supports. But the real thing is that they're out there developing relationships so that those employers trust them. And that they've got a really good idea of what that job is like. So that they're able to help make the best fit for people who are looking for work.

So the job search is supposed to be rapid and that's the job search, not the job find. One of the reasons behind this is that a lot of times in the past, individuals would say, hey, I'd like to work, and they'd think OK, well, let's make sure you're ready. And they might say, well, if you can do 30 days of sobriety, then we'll start looking for work-- no. If they say they want to work, we try to get out there and help them work.

The other things that might have happened in the past is they might have run them through a series of tests and things-- everything from paper and pencil tests to little hand-eye coordination type tests to see how well they could work. Or how much they could maintain. And what we found is that although those are great tests for some things, but for the most part, they're not necessary. And they don't really help.

If we have somebody that has a really severe physical disability accompanying something, we might need some of those tests to see what accommodations might need to be made. But we can do that after we figure out what it is that they want to do. So that rapid job search is we want to see not on average, but the median time between the time they say they'd like to start looking for work and someone meets with an employer, either with them or on their behalf-- we want to see that around 30 days.

The readiness assessments just really don't seem to make much sense. And they don't really work very well.

The services are integrated. And again, this is the part that's very unique. So if any of you are out there working in either mental health treatment teams or substance abuse treatment teams-- how many of those teams have an employment specialist that sits in on your team meeting at least weekly? Because that's the minimum that we like to see from our employment specialists.

They're also out in the community meeting with employers and meeting with their consumers in the communities. So once a week is about a good amount of time. We also have our vocational rehabilitation counselors sit in on those treatment team meetings.

And this might be something that might be more difficult in the substance use field. If you're working with the treatment team, it might be something like either Alcoholics Anonymous, or NA, or one of those because you've got that anonymity. And you don't really have the ability to bring in someone else who can be a support person for the individual that's looking for work if they're not part of the group. But it's something that could happen-- I think. It's just something to be aware of that might be different.

So a couple of the parts that we're looking at is that our individuals are able to make informed choices about the type of work they do, and how much work that they want to do based on their current level of benefits. So in the mental health community, typically the majority of the consumers that were part of IPS programs are on SSDI. And they have limits in terms of the amount of work they can do before their benefits start to be reduced.

So what we want to do is make sure that someone that has training in benefits planning meets with them to cover all aspects of what they are currently receiving. And then looking at what the impact work might be on those benefits. And help those consumers make an informed choice about how much they want to work.

In some ways, some people might think this has backfired on us. Because what we see is a lot of people will work up to the point to where their benefits start to be reduced and then they stop. Other people, though-- from our experience-- shows that they might do that for a couple of years. And then realize, you know what? I could probably work a little bit more. And if I do, then I can get benefits from my employer. And then I don't have to be on benefits anymore.

So the difference is here is that the consumers have their choice in it. And they make an informed choice. And they decide when it's OK to come off benefits. And folks do, do that. It's not impossible. And every site I've worked with around the state of Wisconsin has had at least a couple people that have worked themselves completely off benefits. And are working in the community, and going to outpatient treatment, and living their lives-- that's part of the recovery model. That's what we want to see.

The other part that's going to be a little bit different, too, for substance use disorder is we've got a zero exclusion policy. And that means anybody that's interested that's in part of that treatment team has the ability to go and be in IPS, regardless of their past experiences. Regardless of their current symptomology or their current use patterns.

So for a lot of folks from the old school motto, it's a little bit tough to swallow. Because they were worried about helping somebody find a job and then, what if they showed up under the influence, and they lost their job? Well, those are the kinds of things we call natural consequences. And it's important for everybody to learn that, whether they're in recovery or not.

And the important thing to remember is that employers deal with this all the time, regardless of whether they're in treatment programs or not. That was always the toughest part for new employment specialists to learn is that employers in a lot of fields have to deal with this all the time. And they have people that come in that might be using or they might test positive for substances, and lose their job because of that. And it has nothing to do with that person that helped them get the job, it's that individual's decision that they make.

So their exclusion is probably going to be one of the more interesting parts to integrate into a substance use disorder program. And we've got some anecdotes later, that'll cover some of that.

I'm going to go a little quicker so we can get into Lou's slides. Here, we also talk about time-unlimited supports. So with the way we fund things with IPS, we use braided funding. So there's vocational rehabilitation funding that helps cover the outcomes based on someone learning a job. And then we use Medicaid funding, which is more of the psychosocial-- in Wisconsin, it's our Medicaid programs that fund the symptom-related supports.

So if we had someone who wanted to be a welder, but was also claustrophobic, we would use the DVR funding to help them learn how to be a welder. And we would use the Medicaid funding to help them deal with the symptoms of how do you handle claustrophobia when you're welding helmet comes down and you can't see anything, and it's dark, and closed in, and you're wearing gloves, and all that stuff that might make people have an exacerbation of their symptoms?

And finally, the last principle that's probably the most important one is consumer choice. And that's the individuals in the program have the choice of the type of work they want. Who they're going to disclose to. How much they're going to disclose. Where they want to work. Hours they want to work-- all of those kind of things. And that's probably, the overriding principle of all of them is that we really follow what the person wants. And we help them get the information they need to find a job. And then to keep a job or to get a better job.

So again, I know now, there's another randomized control trial that's not-- just learned about it a couple of weeks ago. Again, that's been tested in rural, urban, international settings and different populations.

So the question that came up is how is Medicaid covering this? In Wisconsin, we've got programs that include skills-based training and psychosocial development in our state plan amendments, or our SPA. And they're covering that because they're also already in a treatment program. So they're in one of our two community mental health treatment programs.

And so the individuals that would be working with them-- the employment specialists-- are able to bill their time against Medicaid when they're working on the symptom-related supports that are keeping them from working. So, like, the claustrophobia example, when someone is helping somebody come up with coping mechanisms for thinking about it or what it's going to be like working on desensitization and that-- that would be different than actually learning how to weld, which is the physical.

How do you put welding equipment together? Put the metal next to each other? What sort of paste or flux or things you need to make the welds happen. That's different than learning how to handle the symptoms that happen when you're-- so Jennifer is asking about a 1915. Yeah, we do have a 1915(i) in Wisconsin. But we've rolled that into our broader-- all three of our treatment programs are all under the same SPA.

And you can send me message offline because it may not apply to everybody on the call. And I'll give you some more information or contact with DHS to help you figure out how we've done that in Wisconsin.

The evidence for IPS, again, looks at the average employment rate for folks in an IPS team was 56%. The average in the control groups-- which was they got the standard employment supports that they had before IPS came along-- that was 23%.

And here's a graph that shows the results of the research trials-- the red bar. And on the left side is the percent employment. The red bar is the IPS level of employment. And the blue bars are the control groups. In some cases, we have multiple control groups.

We have research there, with the VA, different states, different countries. In Northern Europe, we had four or five countries that were all part of one of the treatment research programs. So the one that's Europe in '07-- I think, the Netherlands and other countries were involved in that one. And those are interesting that we still get the same results. Even in countries that have huge social safety nets compared to the United States, we still see the same results.

**Examples:**

And then Lou's going to jump in and talk about IPS infrastructure and other things. And you can feel free to keep typing questions in, and we'll try to respond to those as we see them.

LOUIS KURTZ: Thank you, Bob. That was a good overview of IPS and the principles. So I'm going to talk a little bit more about what kinds of structure or supports do you need if you really want to try to start a program-- an IPS program-- in your area or in your agency.

I would say most of the-- well, all of the states that we have worked with over time-- the 24 states that actually have infrastructure-- it's basically, a state-level partnership between mental health, and SUD departments, and vocational rehabilitation-- those are the two, kind of, like state-level agencies that need to work together to make this happen. And obviously, we need a local provider base. We need a provider in a community that that wants to do this kind of work.

A piece that is very critical to this is the whole training piece. As Bob mentioned, he was a state trainer for Wisconsin. So all of the states that are in the IPS learning collaborative have a form of training that is done. Because employment specialists, obviously, don't come necessarily knowing how to do this work. Some have some experience in employment services, some don't.

And then the other thing about this or any sort of evidence-based practice is you want to know whether or not the service that's being delivered actually meets the standards for the practice. And so with IPS, we call that-- we have what's called a fidelity scale. So there's actually a 25 item scale that measures whether or not the employment services that are being delivered to a group of clients actually meets the model. And you can actually provide the score.

And that, again, it's part of a quality improvement project, where we can tell the agency that here's some areas that you did well in. Here's some areas that you need to do some work in. And then that leads to additional training.

And again, we're referring here to the IPS Supported Employment Center a lot and so you'll be able to go to that website. Because they have provided most of the support to these collaborations in the 24 states that we've talked about.

Let's see, we need to go to another slide. So Bob already mentioned this-- but if you intend to implement IPS, a basic IPS team is usually two full-time employment specialists. You certainly you have to start somewhere so you start can start with one employment specialist. But eventually, you really need to hire two full-time people.

Each employment specialist-- according to fidelity-- can serve up to 20 clients. And those 20 clients-- they're usually a mix of people who are looking for work, and people who are already working and receiving on-the-job long-term supports to maintain their employment. Also-- as Bob mentioned-- the expanded employment team includes local VR counselors, benefit specialists, and possibly, peer support specialists.

It is recommended, if you're starting a new program, that you might want to establish a steering committee. A steering committee is usually comprised of maybe leadership within the agency, perhaps some VR representatives, employers, and other people from the community who can help guide the program as it develops. And to build those relationships in the community that are necessary to help the program succeed.

And again-- as we mentioned-- there needs to be a training and fidelity monitoring component so that the program can deal with issues that need to be improved over time. There may be processes that need to be improved so that the program can over the course of a year or two, become sustainable and actually meet its goals.

So there's a question about the kind of long-term supports that folks receive. So some of those supports from the employment-side can be over the length of time would be working with new managers. Helping with scheduling. Learning assertiveness training so that they can ask for days off when they need it or time like that. And that would typically be provided by the employment specialist. And then they're also part of that mental health treatment team so they're getting other supports from that team-- might be housing and other stuff that's coming from that.

So I want to focus a little bit upon implementation. It's one thing to say I want to provide this service, we're going to hire a couple of people. It's another thing to deal with some of the issues related to implementation. I think, most of us have developed programs over the years has simply said, oh, there's a pot of money or there's a grant. And now we have to perform. And so you hire people and you just get to it.

And what is often missing is a simple plan for how are we going to deal with some of the major issues around implementing any sort of practice? And so, one thing to think about is what kind of context are you are actually implementing this in? Is it a rural site or an urban site? Is it a community where there are a lot of jobs or not so many jobs? Is there leadership support or not?

And so, just to be able to step back and to do a quick assessment of what the context is, is important if you're thinking about implementing this particular practice or just about any evidence-based practice.

One thing that is really, really critical is executive level support. And so you don't want to go into some of these projects unless your CEO, or your clinical director, or somebody is actually on board with this, and understands the practice. Having a financing strategy or a way that you're going to pay for this over time is another key element of an implementation plan.

You need positive attitudes in this. You've got to have staff who are delivering the service. And people who are referring people to the service. They have to understand what the program is, what the model is, and believe that people can work-- people with disabilities can work.

In a lot of agencies, I would, say, over many, many years-- there are a number of people who really doubt, very much, that people with mental illness or people with criminal histories can actually go back to work and succeed. So that's a key element.

And again, I think, it's really important to step back and to think about putting an implementation plan together. And then monitoring that over time and seeing where the rubs are. And then putting some process improvement practices in place to deal with those.

As Bob mentioned already, a couple of things that are a little bit different-- again, most of these IPS programs around the country work with adults with serious mental illness. Certainly, a lot of people with co-occurring disorders.

In my experience with working with a few programs that were traditional-- what we would call traditional substance abuse programs, the integration issue, as Bob mentioned, is a key. Sometimes it's difficult to say, well, who is the treatment team that we're trying to integrate with, depending on the level of care that you might be implementing this program in. Whether it's an IOP, or an outpatient program, or a residential, or a housing program. Who are the actual clinical or treatment folks that we need to talk to and be on the same page with, as far as treatment issues and plans go?

Messaging about the program is critical. You need to be able to-- as we say-- what's the elevator speech about this particular program? You need to be able to say to people what this program is, what's unique about it in a few sentences or less. Because there's a lot of jargon, as with most evidence-based practices.

But you need to be clear about that this is a program that will help individuals who have barriers in their lives become employed in the shortest amount of time possible. It's client-centered, person-centered. And it works. And the evidence shows that these particular practices will help people become employed, stay employed more than any other kind of employment services that you might be familiar with.

A key element-- as Bob mentioned-- is this issue of long-term supports. A lot of people, perhaps in substance abuse programs, they quickly get a job because they might be court-ordered to get a job. It's the only way they can get out of, maybe, a drug court program or whatever. And then they move on, move out of the service area-- whatever.

So providing long-term supports is a little more difficult with people working in substance abuse programs. Because people disappear at times. And so you have to-- again, as part of your implementation plan-- think about, how are we going to deliver those supports? Is this really a program-- because in a traditional IPS supported employment program supports are available for ever, basically. As long as the person needs to come back and they may have to hit a rough spot. They may lose a job, and then they come back for additional services.

Existing agency policies and procedures can be oftentimes, misaligned with the principles of IPS. And so, somebody needs to be able to look at that and say, you know what? This policy is preventing our employment specialists from being able to deliver IPS according to fidelity standards. And so how are we going to deal with that? Is there somebody in leadership who can make that happen in order to make the job easier and be able to serve more clients?

Again many people in substance abuse programs are there because they're court-mandated to be in treatment. They may be court-mandated to have to get employed. And so there is a different sort of pressure, and we need to take that into account as we figure out how to deliver this service.

With any sort of evidence-based practices, I think you need to understand that adaptations to the model will be made whether we like it or not. And we need to do those thoughtfully, but maintaining adherence to the principles of the original model.

Money, financing-- you may be asking already, well, how do we pay for this? How do we pay for these services? One to 20 ratio is a little bit different than what we're probably used to. As with any social service, this is a business. And eventually, it needs to break-even.

I would say that most programs-- new programs trying to deliver IPS, typically start out with some sort of grant funding. There's usually some source of startup funding. I know in our experience in Kentucky, we provided $50,000 grants from our mental health federal block grant. We also used our substance abuse block grant to provide some initial funding to get some programs started.

You can also look to state general revenue sources, and foundation support, or maybe some local city or county funding that might be available. And as Bob said-- ultimately, vocational rehabilitation funding and our Medicaid funding are the things that will sustain programs over time.

I've suggested the programs that they really need to create some sort of a financing plan-- which we oftentimes call a proforma. The bottom line really is you need to figure out, what does it cost to deliver a unit of this service? Or what does it cost to serve one client over a period of time?

If you don't know that, you need to really go back and work with your finance people. And figure out how many case closures, or how many people getting employed, or how many employment plans do we need to develop to meet a certain standard with vocational rehab? And basically, it's again-- how many clients reaching certain milestones within a month that you need to generate enough income to support a full-time employment specialist.

**Additional Case Examples:**

So I'm going to turn it back over to Bob, and he's going to talk to you a little bit about some client level case examples.

BOB MEYER: Thanks, Lou. So one of the things Lou mentioned was these fidelity reviews. And what those are is the IPS Fidelity model has a 25 item scale. Each thing is scored from one to five, with one being you're not doing IPS to five being this meets the gold standard. This would be a program in this area where we recommend somebody else come and look at that to see how they're doing it. And it covers areas of staffing, organization, and the services that they're providing.

So as part of my job, I was doing fidelity reviews at all of our sites-- at least annually. We tried to do them annually. I was getting stretched kind of thin so we might spread it out a little bit.

Early on when the program was just starting, we tried to do them more frequently. So that teams get a chance to see what they're doing well, and where they need to improve. Part of those reviews included client visits, where we'd have consumers that were working or were looking for work and they would come in and talk to our team.

And at one of our sites, one of the employment specialists brought a woman over for the interview. And she poked her head and said OK, are you guys ready? Today's her day off so she's here for your interview. And she came in, and we asked her, hi, how's it going? And she came in, and sat down, she said-- I'm drunk. We said, wow.

So tell us what's going on there. What, are you working or not working? And she went on to explain how in her life when she's not working, she drinks. But when she's going to be working and she knows she has shifts available, she stops drinking the day before. And she doesn't drink at all when she's got shifts coming up that she's scheduled to work for.

She said in her mind, her best option would be to be employed every single day of the week, even a little bit. Because she would know that she needs to stay sober because she wants her job so much. It gives her so much meaning to her life. It gives her more income so that she can live in a little bit better apartment.

The other thing that was really important to her was being able to pick up her grandkids after school. And the only days that her children would let her do that are days that they knew she was working. Because they knew she'd be sober to pick up her grandkids.

So for that individual, there was never a time that we would have been able to say-- if you can maintain seven days sobriety, we're going to help you look for a job. It just wasn't going to happen. Even when they were in the job search time, she explained that she'd have to have calls two and three days ahead of time before she found work to say, remember, we're going to go out Wednesday. We're going to go talk to employers. So make sure that you're ready to be interviewing that day.

And the team kept working with her on it. And she was able to be at the point that we talked to her, she was working five days a week. But she said on those off days, the treatment team has still been working with her. And the harm reduction model-- those off days, the other stuff from her back, her trauma history, and other things would creep back in. And she would find a way to drink on those days that she wasn't working.

And that was just one of those very clear cut examples of if we didn't have zero exclusion, that person would never work. And she wouldn't have any days where she's sober. And now she realizes that yeah, boy, the best case scenario for her at this point in her life would be to work seven days a week, even if it's a couple hours a day.

Some of the other examples that we have of client level work-- it's really consistent with that same model of how do we help somebody learn about what the natural consequences are, and then also move themselves into a place to where they can find employment that fits for what they need? One thing that we've looked at in a lot of places-- in Wisconsin, there are a lot of drinking establishments. I think, when they usually do that list of the top 10 drunkest cities in the United States, I think Wisconsin usually has seven of the top 10.

So for a lot of individuals-- if they struggle with that, that job development comes down to being on a case-by-case basis, the most important part. Because we want to find out, what is the culture like at work? Do people, after work, do they all get together and go out for a drink? Or is there alcohol on the premises that they work in?

Other things that they might look at-- there was one bowling alley that really wanted to hire people. But as the manager started talking about it and he's like, the one thing somebody is going to have to be really comfortable with here is personal contact between people. Because there's this skinny little area where the person they needed working at the bar would be standing there washing glasses and stuff. And people are going back and forth behind them all the time and rubbing up against them.

So some of that looked at that, how do we find a person where physical contact is not going to trigger things? and being around alcohol may not be a trigger? And it took a very special fit to find someone that could work there. Not all of our consumers would have fit that. And that's the important part with IPS, is that we want to make sure that we get the right person in the right job. And that's what we spend a lot of our time working with the employment specialists on.

I think that's what I had for my case. We go into some specific ones we have with other agencies and other examples.

LOUIS KURTZ: I just wanted to talk about a few program level case examples to give you some idea of what is possible. I would say that if you're interested in thinking about developing or implementing IPS in your program, I would go visit another program that is implementing IPS. You'd spend the day there because you can see, pretty clearly, what goes on. And talk to clients, talk to staff. And get some ideas about how you might want to implement it in your area or your region.

So one of the programs that I worked with over a couple of years is this program called Transitions, which is in Covington, Kentucky. It's actually across the river from Cincinnati and northern Kentucky. They started out with a small grant from the state behavioral health department with substance abuse block grant money

So they've been offering IPS since 2016. They started out with one employment specialist, and they've now grown. They have three employment specialists and a supervisor-- a full-time supervisor. And as I said earlier, the caseload size is usually one to 20. So they have capacity now, to serve about 70 clients at a time.

They're serving men and women in residential and housing programs. And their employment rate has been as high as 90% when you look at all the clients that they serve. The rate is a little bit lower-- 64%-- if you include individuals who are not working yet, but at that employment plan stage.

And their fidelity score has been 114, which is considered good fidelity. They've been able to adapt the IPS model to their situation. But still maintain fidelity to the model.

One of the-- just as an example of a couple of items on their fidelity score, they needed to improve on, and one of those items was their focus on the integration with the treatment team. So again, that was probably a lower scoring item that they then go back to their team, or their implementation team, or their steering committee. And figure out, what are we going to do to develop a better strategy for integrating with the treatment or the support that's going on in our agency?

Another example of a program I visited-- in fact, it was the first program I visited years ago-- was in Cape Girardeau, Missouri, on the Mississippi River. They've been offering IPS since 2015. Right now, they have three full-time employment specialists. And one of those-- the supervisor, actually, is recommended that supervisors actually carry a caseload. So that they're able to train, and teach, and mentor for their employment specialists.

At the Gibson Recovery Center in Cape Girardeau, they're providing IPS in their residential and outpatient programs for men and women. Right now, they serve 130 individuals in 2018-- which is a lot of folks over time. And they've managed to have a 53% employment rate-- which is really terrific-- compared to-- as you remember the research studies earlier-- most standard models of employment, the employment rate is not nearly that high.

Another thing that they've been able to do is they decided to seek accreditation for their services. So they managed to get CARF accreditation for community employment services. And they have achieved an exemplary fidelity rating-- which, I believe, is what? 115 or above is considered-- out of a 125 point scale.

And not that programs like this don't have challenges-- and so one of a couple of the things that they have mentioned is that a lot of people, whether they're in a mental health program or a substance abuse program, have past criminal histories. Some people have some really high level convictions. And so that's another aspect-- I think-- of IPS. They pay. They are able to train their employment specialists to work with people who have these barriers, basically. And how do you work through them? And how do you work with employers around that?

Certainly, job retention is an issue. And, of course, in IPS-- if people lose their job after a period of time, we consider that a learning event for people. And what do we do? The employment specialist says OK, well, we're going to we're going to work together, again. And we're going to find another job. And we use that, again, as a learning example to figure out what went wrong with that. And we're going to use that to move forward.

So finally, we want to leave you with a few resources. We would recommend that you go to the Westat IPS Employment Center, which is-- as you can see here-- it's ipsworks.org. And this is the organization that has created and worked with the IPS learning community. And as Bob said, there's 24 states right now that are participating.

We're fortunate in our Great Lakes Mental Health Technology Transfer Center region that five of our six states are actually members of the IPS learning community. So you would find that there is a fairly well-developed infrastructure at the state level. There probably is training and fidelity assessment available. And those would be the people that you would probably want to contact, if you're thinking about starting a program. I think Indiana is the only state in our six-state region that is not part of that learning community right now.

The other thing I could mention is that there is a SAMHSA grant out right now. It's called SAMHSA Transforming Lives Through Supported Employment. And so those grants are available. I think, it's $800,000 a year for five years. So I would encourage you to take a look at that. Go ahead and Google that, and see if you might be interested in applying for that.

**Questions:**

So that's what we have for you today. And we can answer any questions that have come through or anything that Bob didn't answer already.

BOB MEYER: So Marie had a question about including OMT-- outpatient methadone treatment. There was one small pilot study out in Portland, Oregon at a methadone treatment facility. And they, again-- it was such a small study, they didn't list that as a randomized control trial in the other one-- I don't think. But they found the exact same results in the methadone treatment study clinic that about half the people that were getting IPS services were doing well, and getting jobs.

I think they also found as part of that little pilot study that those folks were more likely to continue their treatment at the methadone clinic versus folks that might have dropped out, who were not part of the employment program.

What were the other questions, I think there were-- there's a couple of people typing, now. Oh, you're welcome. I wonder if there are any that we missed. I might scroll up here quick, to see. There's a couple folks still typing.

LOUIS KURTZ: If you have questions after this webinar, you're certainly welcome to email me or Bob. And we can answer your questions offline, here. And our email addresses are up there for you.

BOB MEYER: So one of the questions is, do IPS programs have a targeted employment rate as far as serving a number of people, placing a number of people? And what's interesting is that in the fidelity scale, we don't measure employment rate. We measure, are people getting a diverse type of job? Or are they working with a diverse number of employers? Are they getting to employers quickly?

What we found is it's like the old Field of Dreams movie-- if you build it, they will come. So if you build a program right, the employment rates go along with it. What we do see a connection to is a connection between the fidelity rate or the fidelity score and the employment rate. I think it's every 10 points, we typically see a 5% to 10% increase in employment rates.

In Wisconsin, because we started in our mental health treatment teams-- the background employment rate with those teams was around 18%. And we were able to get that up to 45% on average across all of our sites. Some of our sites consistently average 85% to 90% employment.

It totally depends on the makeup of the team. The employment characteristics where they are locally. The amount of transportation assistance they have-- all those other factors that go into it. But on the most part, we were able to move them from around 18% to 50%

LOUIS KURTZ: And I would say, too-- along with that-- that it's a practical element. I think a lot of supervisors will set goals with their employment specialists. And they will say, we really need to get two job starts a quarter or something. Or we need to have so many people with their employment plan is getting done in the period of time, just standard business. It's still good to have goals for employment specialists and expectations.

BOB MEYER: Yeah, so it's not like we ignore it completely. But it's one of those things that if we saw things-- like we saw that there weren't people getting jobs, and they didn't have enough to even score as far as how diverse the employers are-- that's something we go back to say OK, let's set some goals for getting people out and actually interviewing. Or are they interviewing at places for teams that are brand new?

One of the other questions here is, are employers accepting of the model, and see it expanding in the future? I've seen nothing but expansion from IPS-- at least in Wisconsin. And it seems like state and nationally. When you look at the national stats, as far as the number of people that are in treatment services versus the number of people you have access IPS-- it's a very, very tiny percentage. There are so many more people who could get services from IPS if we could get into those programs.

And the employers-- in my experience-- they love it. Because they've got the employment specialist as a backup, as somebody that can call. A lot of times, placement agencies will plop somebody into a job. They might do a little job coaching to see if they've got it figured out, and then they disappear.

Some don't even do job coaching, they just pop them into a job, and they're gone-- like a temp agency. They really like having that relationship. And that's why the employment staff are really key to it.

And some of the challenges-- exactly-- in recruiting, hiring, and retaining employment staff-- one of the biggest ones that we were seeing, at least in Wisconsin, is that staff would transition into case management roles or into other positions within the agency. In some cases, we actually had folks that transitioned to case management and said, wow, you know what? I spent a lot of time fighting fires there. I really liked IPS because there were a lot of successes.

It's, sort of, this subversive way of getting organizational change. One of the first teams that I went to-- the first few team meetings that I'd sit, and I'd sit like a fly on the wall and listen to what's going on. And all I heard about was bed bugs, and roommate situations, and who's getting kicked out of their apartment. Who got caught drinking, again.

About a year and a half later, I was sitting in the treatment team meeting. And I was sitting next to the manager of the treatment team. And as we were listening to it, I sat back and said, you know what? This is the first time I've heard cheering during a treatment team meeting. And she's, like, you know what? I guess, I didn't really realize that.

And people were cheering when somebody would get a job, or they would have an interview, or they do something that the team didn't think was possible. So that was really cool.

How do you follow federal confidentiality rules and protect client confidentiality while implementing IPS? Again, that comes down to that disclosure and the client choice. If they choose to disclose, then they can work with that employment specialist on how much they want to disclose and to whom.

And again, they might say I don't want to disclose to anybody. And then, we're really looking at working more in the behind the scenes. And letting them apply for jobs on their own. And then trying to help them, as off the radar as we can, if they need it. But that's the main way all of our employment staff-- that's probably when Lou talked about some of those processes and policies that you have to do.

When you've got an outside employment agency working with a medical team, we usually have to have business associates agreements and other things in place. So that those folks can access their electronic medical records-- for instance-- and things like that. And again, they follow those same processes and procedures, just like anyone else on the team would.

Or if you had a mental health treatment team, and you had an outside AODA counselor coming in, it would be the same thing as somebody like that working with that team. Or an outside psychiatrist or an outside therapist working with the team. And our vocational rehabilitation counselors in Wisconsin also follow the same rules. And will also set up that business associates agreements with our state-- in Wisconsin, we have a county-based system. So it's the county-based mental health treatment team.

Let's see-- other questions coming in. We've got just a couple of minutes left. Maybe not.

Let's see if the next thing comes up or not. If not, we're almost out of time here. Any closing thoughts, Lou?

LOUIS KURTZ: No. I would just encourage you-- if you have gotten interested in this practice. And want to talk about it some more or have additional questions-- you can contact us.

BOB MEYER: Any scheduling conflicts with treatment and employment? Yeah, there's always going to be conflicts. So what we do like-- especially with employment-- is if you know you've always got a group meeting on Wednesday mornings or whatever, that's part of that client choice. You'd say, I can work any day, except for Wednesday mornings.

We have consumers who will say, I'll work any day of the week, but I can't work on Sundays. Because that's my time that I go to church or whatever, and I'm with my family. And other people have those same kind of conflicts.

A lot of the folks that we worked with were really looking at part-time employment. So the scheduling conflicts-- it was really learning about assertiveness training and other things. So that they learned how to ask for that time off appropriately, rather than just skipping work and going to their meeting or skipping everything. And then getting bound up with both problems.

So yeah, there's always scheduling conflicts. And part of that is helping people learn, how do you handle that? Because there's going to be scheduling conflicts with just about anything else that goes on.

LOUIS KURTZ: I think we're about at the end of our time. I believe, this session will be recorded, and we will post it to our YouTube channel. And Anne, do you have anything else to add before we close out?

ANN: I do not, thank you.

LOUIS KURTZ: All right well thank you all very much for participating today. And for asking lots of good questions. And we look forward to hearing from you. Thank you very much.

BOB MEYER: Thanks, everyone.